BRIEFING MEMO

DATE: July 28, 2021

TO: Jeanne M. Lambrew, Ph.D. Acting, Commissioner, DHHS

THROUGH: William Montejo, Director, Division of Licensing and Certification

FROM: Larry D. Carbonneau, Manager, Health Care Oversight, DLC
Richard S. Lawrence, Senior Health Care Financial Analyst, DLC

SUBJECT: Application of Issuance of Certificate of Authority – United Healthcare of New England, Inc.

Subject to the Maine Certificate of Need Act of 2002, a person may apply to the superintendent of insurance for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with the Maine Insurance Code. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with, a health maintenance organization without obtaining a certificate of authority. See 24-A M.R.S. §4203 (1).

The superintendent of insurance shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B below. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met as set out in 24-A M.R.S. §4204 (2-A).

A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A.

Met: A letter of Non-Applicability for this project in regard to the Certificate of Need statute was forwarded to the applicant and the Bureau of Insurance on July 7, 2021. As the reason for this determination, the letter of non-applicability cited section §330 (2):

22 M.R.S. §330. *Notwithstanding section 329, the requirements of this Act do not apply with respect to: (2). Activities or acquisitions by or on behalf of a health maintenance organization or a health care facility controlled, directly or indirectly, by a health maintenance organization or combination*

of health maintenance organizations to the extent mandated by the National Health Policy, Planning and Resources Development Act of 1974, as amended, and its accompanying regulations;

B. If the Commissioner of the Department of Health and Human Services has determined that a certificate of need is not required; the Commissioner makes a determination and provides a certification to the superintendent that the following requirements have been met. (Please note that the numbering of the following paragraphs is in accordance with section 4204 (2-A) (B) of Title 24-A. There are no paragraphs numbered (1), (2), or (3) in this section of the statute).

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized -standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care.

Met: The applicant provided a detailed 2021 Quality Improvement Program Description which provides an overview of its Quality Improvement Committee Structure. This overview outlines the essential components for a comprehensive, integrated, and collaborative quality program. The National Quality Oversight Committee (NQOC) directs the QI Program for UnitedHealthcare at the national level and interfaces with other national and regional committees, as applicable. The Board of Directors has delegated responsibility for the oversight of health plan Quality Improvement QI) activities to the NQOC/Regional Quality Oversight Committees (RQOC). The responsibility of the RQOC extends to the following:

- Define state and national/regional accountabilities for patient safety, QI, regulatory and accreditation requirements.
- Review and approve National Policies and Procedures, including network adequacy, network accessibility, quality of care, and operational policies.
- Review reports from inter-segmental partners, as appropriate.
- Patient Safety
- Approve and monitor corrective action plans for inter-segmental partners, as appropriate.
- Patient Safety.
- Review reports from Committees.
- Review and approve all program documents, material and reports integral to program operations and corporate accreditation requirements.
- Review Quality strategies and reporting.

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and non-institutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;

Met: The applicant forwarded a copy of the UnitedHealthcare Employer and Individual, Commercial and Exchange, 2021 Quality Improvement Program Description (QIPD) (Approved by NQOC 12/15/2020).

(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

Met: In order to fulfill the goals and objectives of the QI program and effectively use resources, the QI Program is integrated into the QI activities. This includes, but is not limited to, interactions with Optum, Network Management, National Credentialing Center (NCC), Compliance, UnitedHealthcare Clinical Services, Sales and Operations (Claims, Customer Care and Appeals). Special attention is given to high volume, high risk areas of care and service for each population. Health promotion and health management activities are also an integral part of the QI Program and are specialized according to regulatory requirements, population needs and delivery models within each of the service models. Patient Safety is an integral component of the Program and therefore inherent in planning as well as executing quality initiatives. Program activities are further described on page 7 of the QIPD.

(ii) The organizational structure responsible for quality assurance activities;

Met: The applicant provided a complete description of the organizational structure responsible for quality assurance activities on pages 7-18 of the QIPD. Those responsible include the Board of Directors, National Committees, Regional Committees, Senior Executive Leadership, Corporate Clinical and Regional Quality Management.

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

Met: The Delegation Oversight Governance Committee (DOCG) is an executive level committee responsible for monitoring and approving delegated activities for care providers and intersegment partners related to Claims, Encounters, Credentialing, and Medical management which may include Utilization Management, Complex Case Management, Disease Management, Population health and other contractually agreed upon activities. A complete description of the functions of the DOCG are included on page 13 of the QIPD.

There are four Delegation Oversight Committees (DOC): California DOC, West Region DOC, Central, East, South and a National DOC. Each committee is responsible for ongoing oversight of delegation activities for Claims, Credentialing and utilization management for medical and behavioral health care, disease, and case/care management activities as applicable. A complete description of the functions of the DOC are included on page 14 of the QIPD.

(iv) Confidentiality policies and procedures.

Met: The QI Program is designed to comply with the United Health Group Enterprise Policies related to Ethics and Integrity. Through application of the policies related to Privacy, the QI Program seeks to retain the trust and respect of our members and the public in handling of private information including health, financial, and other personal information.

All employees, contracting practitioners/providers, and agents of the UnitedHealth Group are required to maintain the confidentiality of protected health information, including, but not limited to, member demographic information, medical record content, practitioners confidential information, peer review and quality improvement records. All information used for QI activities is maintained as confidential in accordance with federal and state laws and regulations, including Health Insurance Portability and Accountability Act (HIPPA) Privacy requirements. Information is not considered discoverable.

(v) A system of ongoing evaluation activities;

Met: Page 5 of the QIPD describe the program objectives and program activities undertaken on an ongoing basis.

(vi) A system of focused evaluation activities;

Met: Program activities may vary by product and include but are not limited to the following:

. Measure performance of key indicators of service, clinical quality and safety as identified by the QI Program and in the Quality Improvement Work Plan (QIWP).

. Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, practitioners, and ancillary providers.

. Analyze, identify and address:
a. continuity and coordination of care
b. areas that will improve patient safety
c. member and practitioner satisfaction information
d. access to and availability of care, and
e. the effectiveness of PHM programs and service initiatives.

. Develop programs to address culturally and linguistically diverse membership needs.

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities;

Met: The National Credentialing Committee makes decisions related to initial credentialing and recredentialing of practitioners and organizational providers that may provide care and services to a UnitedHealthcare Member. The committee responsibilities are further outlined on page 9 of the QIPD.

The National Peer Review and Credentialing Policy Committee (NPRCPC) provides a forum for qualified physicians to discuss and take disciplinary action on member cases involving significant concerns about unresolved quality of care issues.

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;

Met: The QIPD provides organization structure and roles for the quality improvement program on page 17 and 18. The UnitedHealthcare Chief Medical Officer provides clinical oversight for all aspects of the national quality program. The National Chief Medical Officer is a senior member of the Executive Management Team and is for providing leadership for the clinical functions of the QI Program, operations, and related outcomes. The Regional CMO is the designated senior physician who is responsible for the implementation of and leadership within the QI Program.

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

Met: The QIPD Section X. pages 19 -23 describes the plan for assessment, identification, selection and study of problems encountered. QI programs including quality and safety of care, Continuity and Coordination of Care, HEDIS, Clinical Program Delivery are described in detail.

(ii) Corrective action, monitoring evaluation and reassessment; and

Met: The QIPD Section X, pages 19-23 describe the applicant's plan for monitoring evaluation and reassessment. QI programs including Medical Record Review, Medical Management/Utilization Management/Utilization Review, Peer Review are described in detail.

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

Met: The QIPD Section X, pages 19-23 describe the collection, interpretation, and analysis of patterns of care rendered to individual patients by individual providers. The Physician Hospital and Performance Monitoring and Designation Programs are described in detail.

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format;

Met: The QIPD Section X, pages 19-23 describe the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation, and report format. The Population Health Management program is described in detail.

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

Met: Ongoing compliance to policies and procedures is assessed through a variety of methods. Providers failing to meet established standards, such as the presence of sanctions or limitations on licensure, instances of poor quality, etc., will be reviewed by the appropriate Committee, with avenues of recourse being corrective actions, sanctions, or provider termination. Reporting to appropriate regulatory bodies will occur as needed.

(6) *The health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Health and Human Services.*

Met: Page 16 of QIPD discusses data collection and taking of minutes. Furthermore, as required in subpart (6) of Section 4204(2-A) (B), unless limited by CMS regulations, UnitedHealthcare commits to make available to DHHS the minutes of quality assurance program activities upon DHHS request.

(7) The health maintenance organization shall ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment of the quality of health and medical care provided to enrollees.

Met: Page 20 of the QIPD describes the plan for monitoring and evaluating the continuity of care and utilization. The Medical Record review and medical Management/Utilization Management/Utilization Review are described in detail.

(8) Enrollee clinical records must be available to the Commissioner of Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and Human Services.

Met: The Medical Record Review program have the following responsibilities in support of quality improvement:

As part of its Quality of Care program, UnitedHealthcare conducts Medical Record review when require by regulatory, contractual, or other business requirements. The audits are completed in accordance with UnitedHealthcare policies and applicable State, Federal or other regulatory requirements. This program should also ensure the availability of clinical records to the Commissioner of the Department of Health and Human Services or authorized

designee for examination and review to ascertain compliance, or as considered necessary by the Commissioner of the Department of Health and Human Services.

(9) The organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

Met: UnitedHealthcare has provided a detailed description of their QI Committee Structure.

Each regulated entity is governed by a Board of Directors or an Executive Committee, which oversees many aspects of the entity's business operations, including several functions relating to Quality oversight which include:
. Receives reports from the National Quality Oversight Committee and/or the appropriate regional committee, including accreditation and STAR Rating information.

. Annually reviews and/or approved the QIPD and QIWP, as well as the Annual QI Evaluation and other reports and information as required or requested.

. As may be appropriate, provides feedback and recommendations to the National Quality Oversight Committee related to reports. Documents and any issues of concerns.

The Regional Chief Medical Officer is the designated senior physician who is responsible for the implementation of and leadership within the QI Program. The Regional CMO is required to maintain a current, unrestricted medical license. Other accountabilities, which may be delegated to a Senior or Market CMO, include, but are not limited to:

. Providing routine reports to the BOD regarding clinical activities.

. Providing management with information for strategic decision making and planning.

. Monitoring/providing oversight of the maintenance of quality health care delivery systems, programs, policies, procedures, and measurements.

. Providing consultative advice to senior management regarding quality and clinical management programs, forecasts, cost/benefit analysis and utilization trends.

. Promoting collaboration using a multidisciplinary approach to act on identified opportunities for improvement.

. Monitoring integrity of functional areas for compliance with state and federal requirements, accreditation standards and company policies.

Additional detailed information regarding UnitedHealthcare's Quality Improvement Committee Structure is provided on pages 7-16 of the QIPD.

The Commissioner of the Department of Health and Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, the commissioner shall specify in what respects the health maintenance organization is deficient.

Recommendation:

CONU concludes that the applicant has satisfied the requirements of 24-A § 4204 (2-A) parts A and B and recommends that this application be **Approved**.